STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455651	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downtown Health and Rehabilitation Center	424 S Adams St Fort Worth, TX 76104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for three of seven residents (Resident #1, Resident #2 and Resident#3) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #2 was free from abuse by Resident #1. The facility failed to ensure Resident #3 was free from verbal abuse by LVN B. This failure could place residents at risk for abuse or neglect that could lead to serious harm.Findings included: Record review of Resident #1's face sheet, dated 05/06/26, reflected a [AGE] year-old male admitted [DATE]. Resident #1 had diagnoses which included: dementia (decline in mental ability), chronic obstructive pulmonary disease (a progressive, irreversible lung disease that restricts airflow and makes breathing difficult), protein-calorie malnutrition (a severe nutritional deficiency resulting from inadequate intake of protein and calories), paranoid schizophrenia (a complex brain disorder marked by psychosis (losing touch with reality) through intense paranoia, delusions (false, fixed beliefs like being watched or targeted), and auditory hallucinations (hearing voices)), muscle weakness, difficulty walking, lack of coordination, reduced mobility, cognitive communication deficit (an impairment in communication caused by underlying disruptions in cognitive processes-such as attention, memory, and executive function rather than primary speech or language deficits), anemia (a condition where your body lacks enough healthy red blood cells or hemoglobin to carry adequate oxygen to your tissues), depression (a common, serious medical illness causing persistent sadness, loss of interest, and physical symptoms that interfere with daily life), mood affective disorder (a mental health condition that primarily impacts your overall emotional state, causing long-term periods of extreme sadness, excessive elation, or both), insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early, often leading to daytime fatigue, irritability, and poor concentration), hypertension (a chronic condition where the force of blood against your artery walls is consistently too high), old myocardial infarction (scar tissue formation in the heart muscle following an injury that occurred more than four weeks ago, or one that was previously undetected), paroxysmal atrial fibrillation (a type of irregular, chaotic heart rhythm where episodes start suddenly and stop on their own within seven days), congestive heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently) and chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should). Record review of Resident #1's Quarterly MDS assessment, dated 04/29/26, reflected a BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #1 was independent with eating and needed setup or clean-up assistance with toileting and supervision with walking 10 feet. The MDS assessment further revealed that Resident #1 used a walker. The MDS assessment under Section E-Behavior, reflected Resident #1 did not exhibit any physical, verbal or other behavior symptoms directed towards others. Record review of Resident #1's care plan, revised 01/29/26, reflected Resident #1 had potential for a mood problem. Interventions included: administering medications as ordered, assisting resident in developing/providing the resident with a program of activities that was (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meaningful and of interest, encouraging and providing opportunities for exercise, physical activity, assisting the resident to identify strengths, positive coping skills and reinforce these, monitoring/recording/reporting to MD PRN risk for harm to self. Resident #1 care plan also revealed he had impaired cognitive function/dementia. Interventions included: administering meds as ordered, communicating with the resident/family/caregivers regarding resident's capabilities and needs and using the resident's preferred name, identifying at each interaction, facing the resident when speaking and making eye contact, reducing any distractions, providing resident with necessary cues-stop and return if agitated, discussing concerns about confusion, disease process, engagingin the resident in simple, structured activities that avoid overly demanding tasks, keeping the resident's routine consistent and trying to provide consistent caregivers as much as possible in order to decrease confusion, monitoring/documenting/reporting to MD any changes in cognitive function, providing a program of activities that accommodate the resident's abilities, providing resident with a homelike environment, reviewing medications and recording possible causes of cognitive deficit. Resident #1 had potential for a mood problem. Interventions included: administering medications as order and monitoring/documenting side effects and effectiveness, assisting the resident in developing/providing the resident with a program of activities that are meaningful and of interest, encouraging and providing opportunities for exercise and physical activity. Assisting the resident to identify strengths, positive coping skills and reinforce them. Monitoring/recording/reporting to MD prn risk for harm to self. Monitoring/recording/reporting to MD prn risk for harming others. Resident #1's care plan also revealed he had a potential for maladaptive behaviors. Interventions included: administering medications as ordered and monitor/document side effects and effectiveness. Anticipating and meeting the residents' needs. Explaining all procedures to the resident before starting and allowing to adjust to changes. Intervening as necessary to protect the rights and safety of others. Approaching and speaking in a calm manner, divert attention, remove from situation and take alternate location as needed. Praise any indication of the resident's progress/improvement in behavior. Record review of Resident #1's progress note, dated 04/22/26 at 4:09 PM written by LVN E, reflected the following: Resident #1 during the end of supervised smoking. Resident #1 stood in front of the of the doorway with both open arms flexed in across position. [Resident #1] [refused] to allow anyone to pass inside the building. Another resident was passing by. The staff redirected resident and deescalated the agitation, which resulted in [Resident #1] striking [Resident #2] in the face, neither residents sustained physical injuries. [Resident #1] was placed on a 1:1 monitoring. NP notified with [family member]. ADON, DON, Abuse coordinator notified. [Resident #2] denied any pain or physical distress in ambulation. Refused to allow vital signs. Safety measures in place. Record review of Resident #2's face sheet, dated 05/06/26, reflected a [AGE] year-old male admitted [DATE]. Resident #2 had diagnoses that included: alcohol dependence with alcohol-induced persisting dementia (chronic alcohol use that cause significant, permanent cognitive decline in multiple domains (memory, reasoning, language) that persists after stopping alcohol consumption), protein-calorie malnutrition (a severe nutritional deficiency resulting from inadequate intake of protein and calories), dysphagia (difficulty or discomfort when swallowing), dementia (decline in mental ability), major depressive disorder (a serious mental health condition characterized by persistent, pervasive low mood, loss of interest in activities (anhedonia), and low energy for at least two weeks), difficulty walking, lack of coordination, reduced mobility, history of falling, muscle weakness, unsteadiness on feet, cognitive communication deficit (an impairment in communication caused by underlying disruptions in cognitive processes-such as attention, memory, and executive function rather than primary speech or language deficits), anemia (a condition where your body lacks enough healthy red blood cells or hemoglobin to carry adequate oxygen to your tissues), hyperlipidemia (high levels of fats), psychotic disorder (a group of severe mental illnesses that disrupt a person's thoughts and perceptions, causing them to lose touch with reality), anxiety disorder (persistent, excessive fear or worry that interferes with daily life, lasting for months rather than being temporary), insomnia (a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early, often leading to daytime fatigue, irritability, and poor concentration), hypertension (a chronic condition where the force of blood against your artery walls is consistently too high), and chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should). Record review of Resident #2's Quarterly MDS assessment, dated 03/12/26, reflected a BIMS score of 03, which indicated severe cognitive impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #2 was independent with eating and needed supervision with toileting, setup assistance when walking 10 feet. The MDS assessment revealed Resident #2 did not use any devices to walk. The MDS assessment under Section E-Behavior, reflected Resident #2 did not exhibit any physical, verbal or other behavior symptoms directed towards others. Record review of Resident #2's care plan, revised 10/24/24, reflected Resident #2 had potential to demonstrate maladaptive behaviors. Interventions included: analyzing of key times, places, circumstances, triggers, and what de-escalates behavior and document, assessing and addressing for contributing sensory deficits, providing provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, giving the resident as many choices as possible about care and activities and if the resident had physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. Record review of Resident #2's progress note, dated 04/22/26 at 4:30 PM written by LVN E, reflected the following: [Resident #2] during a staff supervised smoke break was involved in an altercation with [Resident #1] in which he sustained a slap on the face by the [Resident #1]. Residents were separated [and] safety measures were provided. According to the staff present [Resident #2] was not the aggressor. [Resident #2's] over all demeaner [was] calm, quiet. Skin check was conducted, no visible injuries, no pain or swelling. [Resident #2] denied any discomfort. Contacted the abuse coordinator, ADON, DON and family member. NP was contacted no new orders. Record review of Resident #3's face sheet, dated 05/06/26, reflected a [AGE] year-old male admitted [DATE]. Resident #3 had diagnoses including: heart failure (heart muscle does not pump blood as effectively as it should), personal history of transient ischemic attack and cerebral infarction (indicate a significantly elevated risk for future, more severe strokes, often referred to as a warning stroke), protein-calorie malnutrition (a severe nutritional deficiency resulting from inadequate intake of protein and calories), type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), vascular dementia with mood disturbance (rapid shifts between depression, anxiety, irritability, and apathy, often resulting from brain damage), major depressive disorder (a serious, common mental health condition characterized by persistent, severe sadness, loss of interest (anhedonia), and low energy, lasting at least two weeks), lack of coordination, cognitive communication deficit (an impairment in communication caused by underlying disruptions in cognitive processes-such as attention, memory, and executive function rather than primary speech or language deficits), muscle weakness, unsteadiness on feet, need for assistance with personal care, alcohol abuse, anxiety disorder (persistent, excessive fear or worry that interferes with daily life, lasting for months rather than being temporary), hypertension (a common condition where the force of blood against the artery walls is consistently too high), atherosclerotic heart disease (when fatty deposits called plaque buildup inside the arteries supplying blood to your heart), old myocardial infarction (scar tissue formation in the heart muscle following an injury that occurred more than four weeks ago, or one that was previously undetected)and gastro-esophageal reflux disease (a chronic digestive condition where stomach acid repeatedly flows back into your esophagus). Record review of Resident #3's Quarterly MDS assessment, dated 04/10/26, reflected a BIMS score of 07, which indicated significant cognitive impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #3 was independent with eating and toileting. Resident #3 was able to ambulate independently without any assistive devices. The MDS assessment under Section E-Behavior, reflected Resident #3 did not (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exhibit any physical, verbal or other behavior symptoms directed towards others. Record review of Resident #3's care plan, revised 04/17/25, reflected Resident #3 had potential or uncontrolled pain. Interventions included: administrating analgesia (medication that acts to relieve pain) as per orders, giving 1/2 hour before treatments or care, anticipating the resident's need for pain relief and respond immediately to any complaint of pain, evaluating the effectiveness of pain interventions, reviewing for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact onfunctional ability and impact on cognition. Record review of Resident #3's physician order summary report, dated 05/07/26, reflected in part:Oxycodone-Acetaminophen Oral Tablet 7.5-325 MG (Oxycodone w/Acetaminophen)- Give 1 tablet by mouth every 6 hours as needed for Pain for 30 Days x 14 days. Hold for sedation. Start Date: 05/02/26 and End Date: 06/01/26. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 1:30 AM, reflected the following: [Resident #3] requested a pain pill and was informed that it is to early he stated, FUCK YOU and returned to his room. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 3:00 AM, reflected the following: Pain med. taken to room for resident and [Resident #3] would not accept so med. was wasted/with [LVN D]. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 3:29 AM, reflected the following: Resident #3 ambulated to desk and asked for pain pill. [Resident #3] was informed that the med had been taken to his room, but [LVN B]would give it to him now and he stated, FUCK [YOU] and turned and went to room. During an interview and observation on 05/06/26 at 11:25 AM, Resident #1 stated Resident #2 slapped him in the face first, and he hit him back. Resident #1 stated he was going outside to smoke when it happened. Resident #1 also stated Resident #2 fell when he slapped him. Resident #1 stated Resident #2 always gave him mean faces and asked what he was looking at. Resident #1 stated he believed a short staff lady was outside and separated them. Resident #1 stated staff told him he should not have slapped Resident #2. Resident #1 did not sustain any injuries. Resident #1 did not have any visible marks or bruises. During an interview and observation on 05/06/26 at 11:37 AM, Resident #2 stated he did not know Resident #1. Resident #2 stated maybe Resident #1 hit him but did not remember. Resident #2 stated he avoided fighting. Resident #2 stated if someone hit him, he would report it to the nurse. Resident #2 did not sustain any injuries. Resident #2 did not have any visible marks or bruises. During an interview on 05/06/26 at 2:23 PM, CNA A stated he worked on the memory care unit and witnessed an incident involving Resident #1 and Resident #2. CNA A stated Resident #2 had finished smoking and was going back inside while Resident #1 was going outside at the same time. CNA A stated in the middle of passing each other, Resident #1 got in Resident #2's face. CNA A stated Resident #1 told Resident #2, You have my hat. CNA A stated Resident #2 was about to say something, but Resident #1 yelled in his face saying, your momma, then proceeded and smacked Resident #2 in the face sending him to the ground. CNA A stated he caught Resident #2 head before it hit the ground. CNA A stated he separated the residents and ensured Resident #2 was safe. CNA A stated he then called for help. CNA A stated Resident #2 was assessed, and he did not sustain any injuries. During an interview on 05/07/26 at 1:35 PM, LVN B stated she worked 200 hall on 10:00 p.m. - 6:00 a.m. shift on 05/02/26. LVN B stated she worked with Resident #3. LVN B stated she was responsible for Resident #3's PRN medications. LVN B also stated she did not remember Resident #3 medications but believed he took Oxycodone for pain. LVN B stated on 05/03/26, Resident #3 requested his pain medication, and she gave him one Oxycodone pill. LVN B stated Resident # 3 returned early to get another pill. She stated it had not been six hours after his last administered pain pill. LVN B said she told him to try repositioning himself while lying down or propping his leg up to see if it would alleviate the pain until she could administer his next dose. LVN B stated she informed Resident #3 that she would bring him his pill as soon as it was time. LVN B stated Resident #3 responded to her saying, Fuck you, then returned to his room or walked around in the halls. LVN B stated LVN D was standing at the nurses' station and witnessed when he said it. LVN B stated LVN D told her that she never heard Resident #3 speak that way. LVN B stated approximately 30 minutes before his sixth hour to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive the next pain pill, she went to Resident #3's room and told him she had his pill, but he ignored her. LVN B stated she left his room with the medication and told LVN D that he ignored her. LVN B stated LVN D told her he would probably be back in 15-20 minutes asking for it again. LVN B stated she put the pill in a cup, covered, labeled and put the pill in the narcotics box. LVN B stated LVN D witnessed her do it. LVN B stated Resident #3 returned to the nurse's station asking for his pain pill. LVN B told Resident #3 she had previously gone into his room, and he did not respond. LVN B stated in response Resident #3 told her, Fuck You and walked away. She stated at that time a CNA was going into the restroom and heard it. LVN B stated the CNA stated he did that sometimes. LVN B stated she then disposed of the pill with LVN D as a witness. LVN B stated it was the last time Resident #3 had spoken to her. She stated she did not administer the medication, and he did not get it. LVN B denied ever saying, Fuck you to Resident #3. She stated she did not say anything disrespectful to Resident #3 when he cussed at her. LVN B revealed she had never had any issues with Resident #3 prior to the incident. During an interview on 05/07/26 at 2:11 PM, CNA C stated she worked 10:00 p.m. - 6:00 a.m. shift on 05/02/26. CNA C stated she worked on hall 200 and sat out in the hall during her shift to respond to any resident that needed assistance. CNA C stated she saw Resident #3 walking the hall and assumed he had come from the dining room. CNA C stated she witnessed Resident #3 go to the nurse's station and he asked LVN B for his medication. CNA C stated she heard LVN B tell Resident #3, Now you want to talk to me in the correct way. CNA C stated Resident #3 yelled out, Fuck you! and LVN B said, Fuck you too, I'm not giving you anything! CNA C stated Resident #3's face became red and he put his hand up as if he was frustrated then walked towards his room. CNA C stated it was around 3:30 a.m. when the incident occurred. CNA C stated she reported the incident to LVN D after she returned from her break. LVN D told CNA C that she needed to report the incident to the DON or the Administrator. CNA C stated she called the DON and reported the incident at the end of the shift. CNA C stated the DON told her to write a statement and it put under her door. During an interview on 05/07/26 at 3:55 PM, LVN D stated she worked 10:00 p.m. - 6:00 a.m. on 05/02/26. LVN D stated around 1:00 a.m. she was sitting at the nurse's station with LVN B when Resident #3 asked for his pain medication. LVN D stated LVN B told the resident it was not time, and he could get it at 3:00 a.m. LVN D stated, as she was headed to lunch, she asked Resident #3 if he had taken his pain medication. LVN D stated Resident #3 told her that he did not. LVN D told him he could go to the nurse's station to ask for it because it was after 3:00 a.m LVN D stated Resident #3 thanked her and told her, Okay. LVN D stated when she returned, LVN B asked if she could waste the medication with her. LVN D asked LVN B whose and what medication was it. LVN D stated LVN B told her it was Resident #3's medication. LVN D then stated, He did not come get his pill. I told him to come get his pill from you. LVN B told LVN D when she went to his room to give it to him, he did not acknowledge her. LVN D also stated LVN B told her Resident #3 said, Fuck you. LVN D told LVN B that she heard it earlier, but LVN B told her he said it again. LVN D stated she asked LVN B where the medication was because she would administer it to him. LVN D stated LVN B informed her she was going to waste it because he told her, Fuck you. LVN D stated LVN B told her she also needed to waste it because she had already charted that it was wasted, although she waited to waste it after LVN D got back from her lunch. LVN D stated she asked LVN B if the resident was in pain, why would she waste the medication. LVN D stated LVN B proceeded to dispose of the medication. LVN D stated LVN B put the medication in a plastic pocket which was used to crush pills and threw it in the sharp's container. LVN D stated it did not make sense for LVN B to waste the medication if the resident was in pain since 1:00 a.m. LVN D stated she thought to herself, LVN B would rather waste the medication than administer to Resident #3. LVN D stated as she walked down the hall, CNA C told her about an incident between Resident #3 and LVN B while LVN D was on lunch. LVN D stated CNA C told her while she was sitting on the hall, Resident #3 went to the nurse's station and asked for his pain medication. LVN D stated CNA C stated she did not hear exactly what LVN B initially said to the resident, but she heard Resident #3 say, Fuck you. and LVN B told Resident #3, Fuck you too. LVN D (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, to the administrator of the facility and to other officials including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures for one of seven residents (Resident #3) reviewed for freedom from abuse, neglect, and exploitation. The facility failed to report the incident of alleged verbal abuse on 05/03/2025 for Resident #3. This failure could put the residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychosocial harm. Findings included: Record review of Resident #3's face sheet, dated 05/06/26, reflected a [AGE] year-old male admitted [DATE]. Resident #3 had diagnoses including: heart failure (heart muscle does not pump blood as effectively as it should), personal history of transient ischemic attack and cerebral infarction (indicate a significantly elevated risk for future, more severe strokes, often referred to as a warning stroke), protein-calorie malnutrition (a severe nutritional deficiency resulting from inadequate intake of protein and calories), type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), vascular dementia with mood disturbance (rapid shifts between depression, anxiety, irritability, and apathy, often resulting from brain damage), major depressive disorder (a serious, common mental health condition characterized by persistent, severe sadness, loss of interest (anhedonia), and low energy, lasting at least two weeks), lack of coordination, cognitive communication deficit (an impairment in communication caused by underlying disruptions in cognitive processes-such as attention, memory, and executive function rather than primary speech or language deficits), muscle weakness, unsteadiness on feet, need for assistance with personal care, alcohol abuse, anxiety disorder (persistent, excessive fear or worry that interferes with daily life, lasting for months rather than being temporary), hypertension (a common condition where the force of blood against the artery walls is consistently too high), atherosclerotic heart disease (when fatty deposits called plaque buildup inside the arteries supplying blood to your heart), old myocardial infarction (scar tissue formation in the heart muscle following an injury that occurred more than four weeks ago, or one that was previously undetected)and gastro-esophageal reflux disease (a chronic digestive condition where stomach acid repeatedly flows back into your esophagus). Record review of Resident #3's Quarterly MDS assessment, dated 04/10/26, reflected a BIMS score of 07, which indicated significant cognitive impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #3 was independent with eating and toileting. Resident #3 was able to ambulate independently without any assistive devices. The MDS assessment under Section E-Behavior, reflected Resident #3 did not exhibit any physical, verbal or other behavior symptoms directed towards others. Record review of Resident #3's care plan, revised 04/17/25, reflected Resident #3 had potential or uncontrolled pain. Interventions included: administrating analgesia (medication that acts to relieve pain) as per orders, giving 1/2 hour before treatments or care, anticipating the resident's need for pain relief and respond immediately to any complaint of pain, evaluating the effectiveness of pain interventions, reviewing for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact onfunctional ability and impact on cognition. Record review of Resident #3's physician order summary report, dated 05/07/26, reflected in part:Oxycodone-Acetaminophen Oral Tablet 7.5-325 MG (Oxycodone w/Acetaminophen)- Give 1 tablet by mouth every 6 hours as needed for Pain for 30 Days x 14 days. Hold for sedation. Start Date: 05/02/26 and End Date: 06/01/26. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 1:30 AM, reflected the following: [Resident #3] requested a pain pill and was informed that it is to early he stated, FUCK YOU and (continued on next page)

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	455651	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downtown Health and Rehabilitation Center	424 S Adams St Fort Worth, TX 76104

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returned to his room. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 3:00 AM, reflected the following: Pain med. taken to room for resident and [Resident #3] would not accept so med. was wasted/with [LVN D]. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 3:29 AM, reflected the following: Resident #3 ambulated to desk and asked for pain pill. [Resident #3] was informed that the med had been taken to his room, but [LVN B]would give it to him now and he stated, FUCK [YOU] and turned and went to room. In an interview on 05/07/26 at 1:35 PM, LVN B revealed she worked 200 hall on 10:00pm-6:00am shift on 05/02/26. LVN B revealed she worked with Resident #3. LVN B stated she was responsible for Resident #3's PRN medications. LVN B also stated she did not remember Resident #3 medications but believed he took Oxycodone for pain. LVN B stated on 05/03/26, Resident #3 requested his pain medication, and she gave him one Oxycodone pill. LVN B stated Resident # 3 returned early to get another pill. She stated it had not been six hours after his last administered pain pill. LVN B said she told him to try repositioning himself while lying down or propping his leg up to see if it would alleviate the pain until she could administer his next dose. LVN B stated she informed Resident #3 that she would bring him his pill as soon as it was time. LVN B stated Resident #3 responded to her saying, Fuck you, then returned to his room or walked around in the halls. LVN B stated when he said it, LVN D witnessed standing at the nurse's station. LVN B stated LVN D told her that she never heard Resident #3 speak that way. LVN B stated approximately 30 minutes before his sixth hour to receive, she went to Resident #3's room and told him she had his pill, but he ignored her. LVN B stated she left his room with the medication and told LVN D that he ignored her. LVN B stated LVN D told her he would probably be back in 15-20 minutes asking for it again. LVN B stated she put the pill in a cup, covered, labeled and put the pill in the narcotics box. LVN B stated LVN D witnessed her do it. LVN B stated Resident #3 returned to the nurse's station asking for his pain pill. LVN B told Resident #3 she had previously gone into his room, and he didn't respond. LVN B stated in response Resident #3 told her, Fuck You and walked away. She stated at that time a CNA was going into the restroom and heard it. LVN B stated the CNA stated he did that sometimes. LVN B stated she then disposed of the pill with LVN D as a witness. LVN B stated it the last Resident #3 had spoken to her. She stated she did not administer the medication, and he did not get it. LVN D denied ever saying, Fuck you to Resident #3. She stated she did not say anything disrespectful to Resident #3 cussing at her. LVN B revealed she had never had any issues with Resident #3 prior to the incident. In an interview on 05/07/26 at 2:11 PM, CNA C stated she worked 10:00pm-6:00am shift on 05/02/26. CNA stated she worked on hall 200 and sat out in the hall during her shift. CNA C she saw Resident #3 walking through the hall and assumed he had come from the dining room. CNA C stated she witnessed Resident #3 go to the nurse's station and asked LVN B for his medication. CNA C stated she heard LVN B tell Resident #3, now you want to talk to me in the correct way. CNA C stated Resident #3 yelled out Fuck you and LVN B said, Fuck you too, I'm not giving you anything! CNA C stated Resident #3 face became red and he put his hand up as if he was frustrated then walked towards his room. CNA C stated it was around 3:30am when the incident occurred. CNA C stated she reported the incident to LVN D after she returned from her break. LVN D told CNA C that she needed to report the incident to the DON or the Administrator. CNA C stated she called the DON and reported the incident. CNA C stated the DON told her to write a statement and it put under her door. In an interview on 05/07/26 at 3:55 PM, LVN D stated she worked 10:00pm-6:00am on 05/02/26. LVN D stated around 1:00am she was sitting at the nurse's station with LVN B when Resident #3 asked for his pain medication. LVN D stated LVN B told the resident it was not time, and he could get it at 3:00am. LVN D stated as she was headed to lunch, she asked Resident #3 if he had taken his pain medication. LVN D stated Resident #3 told her that he did not. LVN D told him he could go to the nurse's station to ask for it because it was after 3:00am. LVN D stated Resident #3 thanked her and told her Okay. LVN D stated when she returned, LVN B asked if she could waste the medication with her. LVN D asked LVN B who and what medication was it. LVN D stated LVN B told her it was Resident #3's medication. LVN D then stated, He did not come (continued on next page)

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	455651	A. Building B. Wing	05/07/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get his pill. I told him to come get his pill from you. LVN B told LVN D when she went to his room to give it to him, he did not acknowledge her. LVN D also stated LVN B told her Resident #3 said, Fuck you. LVN D told LVN B that she had heard it earlier, but LVN B told her he had said it again. LVN D stated she asked LVN B where the medication was because she would administer it to him. LVN D stated LVN B had informed her she was going to waste it because he told her, Fuck you. LVN D stated LVN B told her she also needed to waste it because she had already charted that it was wasted, although she waited to waste it after LVN D got back from her lunch. LVN D asked LVN B that the resident was in pain, so why would she waste the medication. LVN D stated LVN B proceeded to dispose of the medication. LVN D stated LVN B put the medication in a plastic pocket which was used to crush it and threw it in the sharp's container. LVN D stated it did not make sense for LVN B to waste the medication if the resident had been in pain since 1:00am. LVN D stated she thought to herself, LVN B rather waste the medication than administer to the resident. LVN D stated as she walked down the hall, CNA C told her about an incident between Resident #3 and LVN B while LVN D was on lunch. LVN D stated CNA C told her while sitting on the hall, Resident #3 went to the nurse's station and asked for his medication. LVN D stated CNA C stated she did not hear exactly what LVN B initially said to the resident, but she heard Resident #3 say, Fuck you. And LVN B told Resident #3 Fuck you too. LVN D stated she told CNA C to call the Administrator because it was abuse. LVN D stated CNA C told her later that morning she had reported the incident to the Administrator. LVN D stated later that day the Administrator reached out to her via text. LVN D stated the Administrator text asked if she had seen or heard any staff being inappropriate with a resident. LVN D stated she informed the Administrator that Resident #3 tried to get his pain medication and LVN B did not give it to him when it was time. LVN D stated she informed the Administrator of LVN B wasting the medication instead of administering the medication. LVN D stated the risk of not administering the medication was the resident's pain would be unrelieved. In an interview on 05/07/26 at 3:16 PM, Resident #3 stated he was asleep when LVN B came into his room. Resident #3 stated he was not sure what she wanted. Resident #3 stated he was unsure of the time, but when he woke, he went to the nurse's station for his pain medication. Resident #3 also stated when he asked for it, he did not remember exactly what LVN B told, but it had to be disrespectful because he got upset. Resident #3 stated it was all uncalled for but one of those things that happened. Resident # revealed he had not received his medication from LVN B. Resident #3 stated he was in pain and went back into his room. During an interview on 05/07/26 at 4:35 PM, the DON stated she worked on 05/03/26. The DON stated when she got to work there was a note from CNA C under her door. The DON stated the note stated Resident #3 told LVN B Fuck you a few times. The DON stated the note further stated that LVN B said, Fuck you back to Resident #3. The DON stated CNA C was down the hall when she heard the cussing between Resident #3 and LVN B. The DON stated she conducted the investigation of the alleged incident. The DON stated she asked Resident #3 if he had any issues with any nurses, issues with receiving his medication, or if anyone said anything that upset him. The DON stated Resident #3 told her no. The DON stated she also talked to other residents and asked if they heard any shouting, cussing or noise on 05/02/26. She stated no residents had heard anything. The DON stated she talked with another aide and she did not hear anything. The DON stated LVN B informed them that Resident #3 cussed at her, but LVN B denied cussing back at the resident. The DON stated she did not have any reason to suspect that it occurred. The DON revealed if she had gotten any other confirmation about the alleged incident, she would have reported it to HHSC. She stated according to policy, the alleged incident should have been reported to HHSC. The DON stated risk of not reporting the alleged incident could affect other residents. During interview on 05/07/26 at 5:02 PM, the Administrator stated she received a call from CNA C regarding the alleged incident. The Administrator stated CNA C told her Resident #3 went to the nurse's station and said, Fuck you to LVN B and LVN B responded saying, Fuck you. The Administrator stated CNA C stated she was down the hall when it occurred. The Administrator stated she asked LVN B what happened. She stated LVN (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B told her Resident #3 came to the nurse's station several times asking for his pain medications and told LVN B, fuck you. The Administrator asked LVN B for her response and she said she did not respond. The Administrator stated LVN B said she did not say anything inappropriate to Resident #3. The Administrator stated she asked another aide, but she did not witness the alleged incident. She stated she asked LVN D if she heard anything inappropriate and was told no. The Administrator stated she received a text response from LVN D with her statement. The Administrator stated that Resident #3 had been to the nurse's station several times requesting his pain medication, but the medication was wasted by LVN B. The Administrator informed that LVN D stated LVN B wasted Resident #3's medication because he told her Fuck you. The Administrator stated she knew the DON would be working on 05/03/26, so she had her investigate the alleged incident. The Administrator stated she was informed that no residents heard anything. The Administrator revealed LVN B was already off during their investigation, so she did not suspend her. The Administrator stated she did not know why she did not report the alleged incident but should have reported it to HHSC. She stated the facility's policy was to report the alleged incident. Record review if the facility's policy titled, Abuse/Neglect, no date, reflected in part the following: E. Reporting1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.2. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called.3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated 8/29/24.a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegationb. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment, were thoroughly investigated for one of seven residents (Resident #3) reviewed for abuse and neglect. The facility did not investigate an incident in which Resident #3 was cussed by LVN B. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. Findings included: Record review of Resident #3's face sheet, dated 05/06/26, reflected a [AGE] year-old male admitted [DATE]. Resident #3 had diagnoses including: heart failure (heart muscle does not pump blood as effectively as it should), personal history of transient ischemic attack and cerebral infarction (indicate a significantly elevated risk for future, more severe strokes, often referred to as a warning stroke), protein-calorie malnutrition (a severe nutritional deficiency resulting from inadequate intake of protein and calories), type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), vascular dementia with mood disturbance (rapid shifts between depression, anxiety, irritability, and apathy, often resulting from brain damage), major depressive disorder (a serious, common mental health condition characterized by persistent, severe sadness, loss of interest (anhedonia), and low energy, lasting at least two weeks), lack of coordination, cognitive communication deficit (an impairment in communication caused by underlying disruptions in cognitive processes-such as attention, memory, and executive function rather than primary speech or language deficits), muscle weakness, unsteadiness on feet, need for assistance with personal care, alcohol abuse, anxiety disorder (persistent, excessive fear or worry that interferes with daily life, lasting for months rather than being temporary), hypertension (a common condition where the force of blood against the artery walls is consistently too high), atherosclerotic heart disease (when fatty deposits called plaque buildup inside the arteries supplying blood to your heart), old myocardial infarction (scar tissue formation in the heart muscle following an injury that occurred more than four weeks ago, or one that was previously undetected)and gastro-esophageal reflux disease (a chronic digestive condition where stomach acid repeatedly flows back into your esophagus). Record review of Resident #3's Quarterly MDS assessment, dated 04/10/26, reflected a BIMS score of 07, which indicated significant cognitive impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #3 was independent with eating and toileting. Resident #3 was able to ambulate independently without any assistive devices. The MDS assessment under Section E-Behavior, reflected Resident #3 did not exhibit any physical, verbal or other behavior symptoms directed towards others. Record review of Resident #3's care plan, revised 04/17/25, reflected Resident #3 had potential or uncontrolled pain. Interventions included: administrating analgesia (medication that acts to relieve pain) as per orders, giving 1/2 hour before treatments or care, anticipating the resident's need for pain relief and respond immediately to any complaint of pain, evaluating the effectiveness of pain interventions, reviewing for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact onfunctional ability and impact on cognition. Record review of Resident #3's physician order summary report, dated 05/07/26, reflected in part:Oxycodone-Acetaminophen Oral Tablet 7.5-325 MG (Oxycodone w/Acetaminophen)- Give 1 tablet by mouth every 6 hours as needed for Pain for 30 Days x 14 days. Hold for sedation. Start Date: 05/02/26 and End Date: 06/01/26. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 1:30 AM, reflected the following: [Resident #3] requested a pain pill and was informed that it is to early he stated, FUCK YOU and returned to his room. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 3:00 AM, reflected the following: Pain med. taken to room for resident and [Resident #3] would not accept so med. was wasted/with [LVN D]. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 at 3:29 AM, reflected the following: Resident #3 ambulated to desk and asked for pain pill. [Resident #3] was informed that the med had been taken to his room, but [LVN B]would (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	give it to him now and he stated, FUCK [YOU] and turned and went to room. Record review of Resident #3's order summary report, dated 05/07/26, reflected in part:Oxycodone-Acetaminophen Oral Tablet 7.5-325 MG (Oxycodone w/Acetaminophen)- Give 1 tablet by mouth every 6 hours as needed for Pain for 30 Days x 14 days. Hold for sedation. Start Date: 05/02/26 End Date: 06/01/26. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 AT 1:30 AM, reflected the following: [Resident #3] requested a pain pill and was informed that it is to early he stated, FUCK YOU and returned to his room. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 AT 3:00 AM, reflected the following: Pain med. taken to room for resident and [Resident #3] would not accept so med. was wasted/with [LVN D]. Record review of Resident #3's progress note written by LVN B, dated 05/03/26 AT 3:29 AM, reflected the following: Resident #3 ambulated to desk and asked for pain pill. [Resident #3] was informed that the med had been taken to his room but I would give it to him now and he stated, FUCK [YOU] and turned and went to room. In an interview on 05/07/26 at 1:35 PM, LVN B revealed she worked 200 hall on 10:00pm-6:00am shift on 05/02/26. LVN B revealed she worked with Resident #3. LVN B stated she was responsible for Resident #3's PRN medications. LVN B also stated she did not remember Resident #3 medications but believed he took Oxycodone for pain. LVN B stated on 05/03/26, Resident #3 requested his pain medication, and she gave him one Oxycodone pill. LVN B stated Resident # 3 returned early to get another pill. She stated it had not been six hours after his last administered pain pill. LVN B said she told him to try repositioning himself while lying down or propping his leg up to see if it would alleviate the pain until she could administer his next dose. LVN B stated she informed Resident #3 that she would bring him his pill as soon as it was time. LVN B stated Resident #3 responded to her saying, Fuck you, then returned to his room or walked around in the halls. LVN B stated when he said it, LVN D witnessed standing at the nurse's station. LVN B stated LVN D told her that she never heard Resident #3 speak that way. LVN B stated approximately 30 minutes before his sixth hour to receive, she went to Resident #3's room and told him she had his pill, but he ignored her. LVN B stated she left his room with the medication and told LVN D that he ignored her. LVN B stated LVN D told her he would probably be back in 15-20 minutes asking for it again. LVN B stated she put the pill in a cup, covered, labeled and put the pill in the narcotics box. LVN B stated LVN D witnessed her do it. LVN B stated Resident #3 returned to the nurse's station asking for his pain pill. LVN B told Resident #3 she had previously gone into his room, and he didn't respond. LVN B stated in response Resident #3 told her, Fuck You and walked away. She stated at that time a CNA was going into the restroom and heard it. LVN B stated the CNA stated he did that sometimes. LVN B stated she then disposed of the pill with LVN D as a witness. LVN B stated it the last Resident #3 had spoken to her. She stated she did not administer the medication, and he did not get it. LVN D denied ever saying, Fuck you to Resident #3. She stated she did not say anything disrespectful to Resident #3 cussing at her. LVN B revealed she had never had any issues with Resident #3 prior to the incident. In an interview on 05/07/26 at 2:11 PM, CNA C stated she worked 10:00pm-6:00am shift on 05/02/26. CNA stated she worked on hall 200 and sat out in the hall during her shift. CNA C she saw Resident #3 walking through the hall and assumed he had come from the dining room. CNA C stated she witnessed Resident #3 go to the nurse's station and asked LVN B for his medication. CNA C stated she heard LVN B tell Resident #3, now you want to talk to me in the correct way. CNA C stated Resident #3 yelled out Fuck you and LVN B said, Fuck you too, I'm not giving you anything! CNA C stated Resident #3 face became red and he put his hand up as if he was frustrated then walked towards his room. CNA C stated it was around 3:30am when the incident occurred. CNA C stated she reported the incident to LVN D after she returned from her break. LVN D told CNA C that she needed to report the incident to the DON or the Administrator. CNA C stated she called the DON and reported the incident. CNA C stated the DON told her to write a statement and it put under her door. In an interview on 05/07/26 at 3:55 PM, LVN D stated she worked 10:00pm-6:00am on 05/02/26. LVN D stated around 1:00am she was sitting at the nurse's station with LVN B when Resident #3 asked for his pain medication. LVN D stated LVN B told (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident it was not time, and he could get it at 3:00am. LVN D stated as she was headed to lunch, she asked Resident #3 if he had taken his pain medication. LVN D stated Resident #3 told her that he did not. LVN D told him he could go to the nurse's station to ask for it because it was after 3:00am. LVN D stated Resident #3 thanked her and told her Okay. LVN D stated when she returned, LVN B asked if she could waste the medication with her. LVN D asked LVN B who and what medication was it. LVN D stated LVN B told her it was Resident #3's medication. LVN D then stated, He did not come get his pill. I told him to come get his pill from you. LVN B told LVN D when she went to his room to give it to him, he did not acknowledge her. LVN D also stated LVN B told her Resident #3 said, Fuck you. LVN D told LVN B that she had heard it earlier, but LVN B told her he had said it again. LVN D stated she asked LVN B where the medication was because she would administer it to him. LVN D stated LVN B had informed her she was going to waste it because he told her, Fuck you. LVN D stated LVN B told her she also needed to waste it because she had already charted that it was wasted, although she waited to waste it after LVN D got back from her lunch. LVN D asked LVN B that the resident was in pain, so why would she waste the medication. LVN D stated LVN B proceeded to dispose of the medication. LVN D stated LVN B put the medication in a plastic pocket which was used to crush it and threw it in the sharp's container. LVN D stated it did not make sense for LVN B to waste the medication if the resident had been in pain since 1:00am. LVN D stated she thought to herself, LVN B rather waste the medication than administer to the resident. LVN D stated as she walked down the hall, CNA C told her about an incident between Resident #3 and LVN B while LVN D was on lunch. LVN D stated CNA C told her while sitting on the hall, Resident #3 went to the nurse's station and asked for his medication. LVN D stated CNA C stated she did not hear exactly what LVN B initially said to the resident, but she heard Resident #3 say, Fuck you. And LVN B told Resident #3 Fuck you too. LVN D stated she told CNA C to call the Administrator because it was abuse. LVN D stated CNA C told her later that morning she had reported the incident to the Administrator. LVN D stated later that day the Administrator reached out to her via text. LVN D stated the Administrator text asked if she had seen or heard any staff being inappropriate with a resident. LVN D stated she informed the Administrator that Resident #3 tried to get his pain medication and LVN B did not give it to him when it was time. LVN D stated she informed the Administrator of LVN B wasting the medication instead of administering the medication. LVN D stated the risk of not administering the medication was the resident's pain would be unrelieved. In an interview on 05/07/26 at 3:16 PM, Resident #3 stated he was asleep when LVN B came into his room. Resident #3 stated he was not sure what she wanted. Resident #3 stated he was unsure of the time, but when he woke, he went to the nurse's station for his pain medication. Resident #3 also stated when he asked for it, he did not remember exactly what LVN B told, but it had to be disrespectful because he got upset. Resident #3 stated it was all uncalled for but one of those things that happened. Resident # revealed he had not received his medication from LVN B. Resident #3 stated he was in pain and went back into his room. In an interview on 05/07/26 at 4:35 PM, the DON stated she worked on 05/03/26. The DON stated when she got to work there a note from CNA C under her door. The DON stated it stated Resident #3 told LVN B Fuck you a few times. The DON stated the note further stated that LVN B said, Fuck you back to Resident #3. The DON stated CNA C was down the hall when she heard the cussing between Resident #3 and LVN B. The DON stated she conducted her investigation on the alleged incident. The DON stated she sked Resident #3 if he had any issues with any nurses, issues with receiving his medication, or if anyone said anything that upset him. The DON stated Resident #3 told her no. The DON stated she also talked to other residents and asked if they heard any shouting, cussing or noise the night before. She stated no residents had heard anything. The DON stated she talked with another aide and she did not hear anything. The DON stated she did not have any reason to suspect that it occurred. The DON revealed if she had gotten any other confirmation about the alleged incident, she would have reported it to HHSC. She stated according to policy, the alleged incident should have been reported to HHSC. The DON stated the risk of not reporting the alleged (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455651	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downtown Health and Rehabilitation Center	424 S Adams St Fort Worth, TX 76104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident was it could affect other residents alleged abuse or neglect not being investigated. In interview on 05/07/26 at 5:02 PM, the Administrator stated she received a call from CNA C regarding the alleged incident. The Administrator stated CNA C told her Resident #3 went to the nurse's station and said, Fuck you to LVN B and LVN B responded saying, Fuck you. The Administrator stated CNA C stated she was down the hall when it occurred. The Administrator stated she asked LVN B what had happened. She stated LVN B told her Resident #3 came to the nurse's station several times asking for his pain medications and told LVN B, fuck you. The Administrator asked LVN B for her response and she said she did not respond. The Administrator stated LVN B said she did not say anything inappropriate to Resident #3. The Administrator stated she asked another aide, but she did not witness the alleged incident. She stated she asked LVN D if she had heard anything inappropriate and was told no. The Administrator stated she knew the DON would be at the 05/03/26, so she had her investigate the alleged incident. The Administrator stated she was informed that no residents heard anything. The Administrator revealed LVN B was already off during their investigation, so she did not suspend her. The Administrator stated she did not know why she did not report the alleged incident but should have reported it to HHSC. She stated the facility's policy was to report the alleged incident. Record review if the facility's policy titled, Abuse/Neglect, no date, reflected in part the following: F. Investigation Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. 1. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC.2. After receipt of the allegation the Abuse Preventionist and administrator in conjunction with Risk Management will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC per reporting guidelines found in Provider letter 19-17.3. A report to the appropriate agency will include the following:c. The name and address of the suspected victim.d. The name and address of the suspected victim's care giver, if known.e. The nature and extent of any injuries resulting from the suspected abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injury of unknown source.f. The nursing facility will make an addendum to any reportable incident in its report to HHSC if the resident subsequently experiences a negative outcome.g. Other pertinent information as available. The written report must be sent to HHSC no later than the fifth working day after the initial report. The facility will use the designated state reporting form.4. With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee(s) will immediately be suspended pending an investigation.The employee will have an opportunity to present a written statement to answer the allegation(s)of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The employee will have the opportunity to be advised of the outcome of the investigation in the determination of disciplinary action and/or reinstatement.5. Abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property of residents by employees of any facility will be grounds for immediate termination.6. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s). A copy of the written report will accompany any personnel action deemed necessary. If a personnel action occurs, a copy of all pertinent documents will be placed in the employee's personnel file.7. The facility will report and cooperate with any and all investigations concerning reports of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source by the company's employees as set forth in state law (including to the state survey and certification agency).